BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

TREVOR R. EDER	)	
Claimant	)	
V.	)	
	)	
HENDRICK TOYOTA	)	Docket Nos. 1,064,108
Respondent	)	& 1,064,109
and	)	
	)	
HARTFORD INSURANCE COMPANY OF THE MIDWEST	)	
Insurance Carrier	)	

ORDER

Claimant, by and through Keith L. Mark, of Mission, requested review of Administrative Law Judge Steven J. Howard's February 12, 2015 Award. Jeff S. Bloskey, of Overland Park, Kansas, appeared for respondent and its insurance carrier (respondent). The Board heard oral argument on August 11, 2015.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the Award's stipulations.

CASE STATEMENTS

Docket No. 1,064,108 concerns claimant's assertion he sustained injury by repetitive trauma to his cervical spine through June 22, 2011. The judge found claimant failed to establish he sustained an accident on June 22, 2011. On appeal, claimant argues the Judge erred when using K.S.A. 44-508(d) to determine compensability of a repetitive trauma injury. He further argues respondent received timely notice of his injury. Claimant contends the prevailing factor for his need for medical treatment and his disability was his repetitive trauma injury through June 22, 2011, and he sustained a 15% whole body disability. Claimant contends he is entitled to temporary total disability (TTD) benefits from June 22, 2011, through December 15, 2011, and respondent is responsible for paying various medical expenses.

Respondent argues Docket No. 1,064,108 is not compensable because claimant's injuries were caused by "normal non-employment" activities claimant performed as a side job at home, claimant did not consider his injuries work related until he retained counsel and his injuries were an aggravation of a preexisting condition. Respondent contends claimant did not provide timely notice of his alleged injury. Respondent argues claimant is not entitled to TTD because he received paid time off and short term disability for his time off work, and no physician took him off work. Respondent contends claimant is not entitled to payment for medical treatment which he sought on his own.

The other case, Docket No. 1,064,109 concerns a compensable injury by accident to claimant's neck on March 5, 2012. The Judge found claimant had a preexisting 15% whole body impairment involving his neck, he sustained a 10% impairment to the body as a whole for the March 5, 2012 accidental injury and sustained a 14.5% work disability based on a 29% wage loss and a 0% task loss. The judge also awarded claimant future medical benefits. The award was silent regarding a credit to respondent based on preexisting impairment.

Claimant argues he sustained a 17.5% permanent partial impairment and a 50.75% work disability. He asserts, as a matter of equity, that restrictions from both injuries should be used to determine his task loss, even though he stipulated the first claim was for functional impairment only. Claimant also argues he is entitled to future medical treatment and unauthorized medical treatment for both injuries.

Respondent contends claimant sustained a 10% whole body permanent partial functional impairment and is not entitled to work disability because he earned more than his wages with respondent before he voluntarily resigned and sustained no task loss. Respondent contends claimant is not entitled to future medical treatment because he did not present evidence additional medical treatment will be required.

ISSUES

The issues in Docket No. 1,064,108 are:

1. Is claimant's asserted injury by repetitive trauma compensable?

2. Did respondent receive proper notice of the alleged injury by repetitive trauma?

3. If compensable, what is the nature and extent of claimant's disability?

4. Is claimant entitled to TTD benefits from June 22 until December 15, 2011?

5. Is respondent responsible to pay medical expenses totaling $81,043.86, medical reimbursement totaling $6,097.40, out-of-pocket prescription costs totaling $735.17, medical mileage reimbursement totaling $155.28, future medical treatment and unauthorized medical treatment?

The issues in Docket No. 1,064,109 are:

1. What is the nature and extent of claimant's disability?

2. Is claimant entitled to future and unauthorized medical treatment?

FINDINGS OF FACT

Claimant worked for respondent as an automotive technician performing mechanical work beginning in 2003. His work involved significant lifting, bending and awkward positions. The heaviest items he lifted were 120-150 pound differentials. He regularly lifted 30-60 pound brake drums and routinely rotated tires and wheels weighing 40-60 pounds apiece. Claimant testified he carried 100-200 pound engine blocks, often with a coworker's help. He laid on vehicle floorboards and looked up to perform dash wiring. When working on frames for Tundras and Tacomas, claimant worked with his hands above his head with his chin tilted up. Claimant worked with his hands lifted above his head for extended periods of time to work on vehicles on a lift, such as when replacing brake lines.

Claimant testified his pain in his neck and shoulder area began while performing his job duties, including working on Tacoma and Tundra frames, about two to three months prior to June 22, 2011. Claimant had generalized aches and pains involving his neck and shoulders and saw chiropractors for these problems. Claimant associated his pain with lifting heavy items, looking up and doing his job for eight years. Claimant testified he never had treatment for his neck or injured his neck before working for respondent.

Before June 2011, claimant did mechanic work at home for a used car lot, friends and family. Such work included brake work, turning rotors, replacing brake pads, alternators, and window motors, but no heavy lifting. Claimant testified because he did not have help lifting at home, he did not do jobs that required as much heavy lifting as when he worked for respondent. Claimant testified he has a lift at home, so he worked in the same position looking up with his hands in the air. Claimant spent less time in awkward positions at home because he would work only 60-90 minutes at a time. If claimant worked 60 hours in a week for respondent, he worked 10 hours at home. If claimant worked 40 hours for respondent, he would work up to 15 hours at home. Claimant testified his work at home did not injure his neck.

One "Monday" morning, on June 22, 2011, claimant woke up with shooting pain in his neck beyond a normal ache or pain.[1] Claimant testified he did not recall if he worked at home over the weekend, but did not think he did. Inconsistently, he also testified he did not work over the weekend and did nothing at home over the weekend to cause his injury.

Claimant phoned Scott Kelford, respondent's service manager, and told him he would not be able to work that day. According to claimant, Mr. Kelford asked him if he had been hurt at work, and claimant told him he did not know if he had been hurt at work or if he was hurt from doing something else. In any event, claimant did not affirmatively tell Mr. Kelford he had a work-related injury.

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[1] Cont. of R.H. Trans. at 14, 62, 70. June 22, 2011 was a Wednesday.

Claimant went to work that day and reported his injury to Mr. Kelford. Claimant testified he did not specifically tell Mr. Kelford his work duties caused the problems and he did not know what caused his injury.[2] He further testified:

> Q. When you talked to Scott, did you tell him that it wasn't a one-time accident, but you felt that these ongoing work duties were causing your neck complaints?
>
> A. I told Scott I did not have a specific event, as you mentioned, but I didn't know where else that it could have happened other than at work.
>
> . . .
>
> A. As I mentioned earlier, at that time we were doing the frames and in my remembrance of the conversation I had with Scott, it was probably something to do with the frames.[3]

Claimant could not recall his exact conversation with Mr. Kelford and he did not believe they discussed specific work duties that may have caused his symptoms, but he testified his discussion with Mr. Kelford "probably" concerned working with vehicle frames.[4]

Claimant completed, signed and turned in an accident report and Mr. Kelford sent him to a workers compensation clinic, Corporate Care.[5] Claimant noted respondent would not have sent him to a workers compensation clinic had he been hurt at home. Claimant told the Corporate Care doctor he was not sure his problems were work related. He testified the doctor asked for a specific accident date, but he did not have one, so he told the doctor his heavy job duties may have contributed to his injuries.[6] According to claimant, the doctor did not think his problems were work related and Corporate Care did not offer additional treatment because he could not identify a specific work-related event. Claimant testified the doctor told him he had to find treatment on his own. The doctor indicated claimant's job status was off duty as of June 30, 2011.[7]

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[2] *Id.* at 16-17.

[3] *Id.* at 18-19. Claimant also testified his discussion with Mr. Kelford "might" have concerned working with vehicle frames. *Id.* at 19.

[4] *Id.* at 19.

[5] *Id.* at 17-18.

[6] *Id.* at 20.

[7] The only 2011 report from Corporate Care discussed at the Continuation of the Regular Hearing and by both Drs. Koprivica and Pratt is dated June 30, 2011, a Thursday.

Because Corporate Care declared his condition unrelated to his work, claimant sought treatment with his personal physician, Dr. Crane. Claimant did not tell Dr. Crane he thought his neck symptoms were related to his work. Claimant did not ask respondent for additional medical treatment for his asserted repetitive neck injuries after his single visit to Corporate Care.

Claimant was off work June 22 to December 15, 2011. Claimant went on his own to Paul O'Boynick, M.D. Claimant testified he asked Dr. O'Boynick to complete a short-term disability form to indicate his condition was not work related. Dr. O'Boynick filled out such a form on July 26, 2011, in which he indicated claimant's condition was not work related. Dr. O'Boynick performed claimant's first neck surgery, a fusion at C6-7, on August 9, 2011. Following surgery, claimant received physical therapy. Dr. O'Boynick released him to return to full duty work on December 16, 2011.

Claimant did not tell Dr. O'Boynick his neck injury was work related. Claimant testified Dr. O'Boynick told him if his condition was work related, he would not perform surgery. Claimant testified he told Dr. O'Boynick his neck condition was not work related because he wanted the doctor to perform his surgery.

Claimant also saw Dr. Tenny for a second opinion, but he did not tell Dr. Tenny his neck injury was work related. Claimant acknowledged he told Dr. Tenny he had worked in his shop over the weekend and awoke the following Monday morning with severe pain in his neck. Claimant acknowledged both Drs. O'Boynick and Tenny did not give him permanent work restrictions.

While claimant was off work, he received his regular wages as paid time off or vacation pay for the first two or three weeks, then he applied for short-term disability. Claimant's short term disability benefits of $840 per week began July 29, 2011, and became long-term disability benefits at the same rate through December 14, 2011.

After Dr. O'Boynick released claimant, he returned to work for respondent as an automotive technician. Claimant testified Dr. O'Boynick released him with no restrictions, and claimant returned to his same job with a raise.

On March 5, 2012, while torquing down a cylinder head claimant felt pain in his neck. He testified he reported the injury to Mr. Kelford, filled out an accident report and was sent to Corporate Care on March 5 or 6. According to claimant, because he had a specific accident, respondent accepted his injury as compensable and authorized treatment. Claimant started physical therapy.

Claimant started working as shop foreman on March 19, 2012. In July or August 2012, claimant began searching for lighter work.

Claimant was referred to Alexander Bailey, M.D., a board certified orthopedic surgeon, who evaluated claimant on April 5, 2012, for only the March 5, 2012, accident. Dr. Bailey determined a causal relationship between claimant's injury and his work for respondent. Dr. Bailey diagnosed status post cervical fusion, cervical sprain and bilateral radicular arm pain from the work accident on March 5, 2012. Dr. Bailey ordered an MRI that showed a new injury at C5-6, which he characterized at different times as either disc bulging or a herniated nucleus pulposus, adjacent to claimant's prior fusion at C6-7.

Dr. Bailey provided claimant conservative care including physical therapy, medication management and three epidural steroid injections. Dr. Bailey's June 7, 2012 note indicated claimant was miserable and frustrated. Because claimant failed to improve with conservative treatment, Dr. Bailey recommended surgical intervention.

Claimant continued working as a shop foreman until June 19, 2012.

Dr. Bailey performed neck surgery on July 26, 2012, including removing the hardware from the previous fusion, removing the disk, grafting the bone, refusing C6-7 and fusing C5-6. Dr. Bailey characterized the surgery as a two-level fusion.[8]

In addition to his other testimony regarding notice for his asserted repetitive injuries, claimant testified he did not tell Mr. Kelford his work duties for respondent caused his physical problems until his second surgery.[9]

Claimant testified he received TTD benefits from July 26 to September 30, 2012, when Dr. Bailey released him to return to work with restrictions. Respondent was able to provide claimant work within Dr. Bailey's restrictions. Claimant was promoted to shop foreman, but asked to be placed back as a technician to make more money. Claimant returned to work in October and had a pay raise.

According to Dr. Bailey's October 11, 2012 report, claimant did well after surgery, but his symptoms returned after performing light duty work for a week. Claimant testified his neck pain became "unbearable" from lifting at work.[10] Dr. Bailey provided physical therapy and an MRI scan which showed no gross evidence of significant abnormality or complications. Dr. Bailey recommended four more weeks of physical therapy and believed claimant would then reach maximum medical improvement (MMI).

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[8] Bailey Depo. at 20-21. Drs. Koprivica and Pratt also noted claimant's second surgery was a two-level fusion.

[9] Cont. of R.H. Trans. at 16.

[10] *Id.* at 34.

When Dr. Bailey saw claimant on November 8, 2012, he still had subjective complaints. Claimant had been working regular duty. On December 27, 2012, Dr. Bailey released claimant from active care at MMI with a full duty release. On January 6, 2013, Dr. Bailey rated claimant with a 15% permanent partial whole body impairment related only to the March 5, 2012 injury.

On January 24, 2013, claimant returned to Dr. Bailey with neck and arm pain, as well as headaches. Dr. Bailey prescribed injection therapy. Dr. Bailey noted claimant's continued difficulties "may be related to a desire to alter his job position."[11] Claimant was seeking different work. Dr. Bailey noted alternate employment would be "fruitful."[12]

Claimant testified he returned to Dr. Bailey in late-January and the doctor referred him to Dr. Lair, a pain management specialist. Claimant testified Dr. Lair's treatment included various injections, nerve blocks and various medications, but nothing helped. Claimant testified Dr. Lair referred him to Dr. Chaudhuri for acupuncture.

Claimant testified he had chronic pain in his neck and difficulties performing his work for respondent, including difficulty lifting, being in awkward positions and having pain from continuous headaches. Lifting tires day after day made his neck pain unbearable. Claimant testified during the four months he returned to work for respondent, he had a difficult time working and he could no longer perform his job duties because of his neck pain. Claimant testified Mr. Kelford knew he was having neck problems. Claimant also told respondent he was having neck problems, would not be able to do the job much longer and needed to find something different to do. Claimant indicated he discussed modifying his duties with respondent. A shop foreman position was discussed, but there was no money in the budget for the position.

On January 31, 2013, claimant filed applications for hearing for his asserted injury by repetitive trauma through June 22, 2011, as well as his March 5, 2012 injury by accident. In addition to his other testimony regarding notice, claimant testified he did not tell respondent his neck problems were work related until filing workers compensation claims against respondent.

Claimant turned in his two-week notice to resign to Mr. Kelford effective February 15, 2013. Claimant testified he resigned because he could not keep doing his job any longer on account of his neck. Claimant did not discuss his reasons for resigning. The following Monday, February 18, 2013, claimant started working for Zurich as a claims adjuster, a sedentary desk job.

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[11] Bailey Depo., Ex. 2 at 8.

[12] *Id.*

Dr. Bailey examined claimant on March 7, 2013, for neck pain and headaches. He released claimant to regular duty and scheduled him to return in four weeks, but the doctor was concerned claimant was reluctant to advance toward case closure, despite having been provided all treatment options.

Dr. Bailey examined claimant on April 4, 2013. Claimant reported his neck and arm pain was worse, as well as headaches. Claimant reported medication did not help. He wanted further workup and was convinced something was significantly wrong. Claimant's x-rays showed no concerns. Dr. Bailey expressed concern that claimant was unwilling to close his case. The doctor ordered a repeat MRI scan and a CT myelogram.

Dr. Bailey last saw claimant on April 16, 2013. He again released claimant at MMI to return as needed. Dr. Bailey found no alteration of claimant's impairment rating and did not feel further treatment was necessary. Review of the MRI and CT myelogram showed no gross abnormalities and a good fusion. Dr. Bailey did not restrict claimant's physical activities when he released him on a return as needed basis. Dr. Bailey repeatedly testified any further care or treatment will not have any clinical benefit for claimant's cervical spine condition, but he agreed if claimant were chronically taking anti-inflammatory medication, it would not be unusual to have liver function testing.

Claimant understood that after he was released by Dr. Bailey, respondent was not providing any authorized medical treatment and that Dr. Bailey was not making any more referrals. Still, claimant went on his own to Drs. Hamilton, Reeves, Lair and Chaudhuri, as well as Stacey Carter, Ph.D. (a psychologist). After being released by Dr. Bailey, claimant did not make demand upon respondent for additional medical treatment. Claimant testified he sought treatment on his own – against the advice of his counsel – because he was having significant problems. He testified he knew his bills would be unauthorized expenses and his group health insurance would likely not pay the bills. Claimant did not tell the doctors his problems were work related. Claimant's health insurance carrier paid for all his medical bills except for bills incurred at Corporate Care.

At claimant's attorney's request, P. Brent Koprivica, M.D., a board certified occupational medicine physician, first evaluated claimant on April 1, 2013. About 98-99% of Dr. Koprivica's examinations are on behalf of claimants' attorneys. Dr. Koprivica reviewed records and took a history from claimant. Claimant's complaints were ongoing neck pain, radicular symptoms, radiating symptoms into his right arm and daily headaches. Claimant had pain with lifting and carrying, which limited how much he lifted and carried. Claimant took narcotic pain medication for his headaches and severe pain. Claimant also took Flexeril and Lyrica. Dr. Koprivica opined claimant's surgery was successful in preventing neurological compromise, but claimant had significant pain in his neck which affected the function in his shoulders.

Dr. Koprivica found claimant had no exaggerated pain behaviors and his clinical presentation represented his objective impairment. Physical examination also showed claimant's radicular symptoms were coming from his neck and he had strength loss in his right hand. Dr. Koprivica diagnosed claimant with a herniated disc at C6-7 for which he underwent surgery as a result of his job as an auto technician. The cumulative injury to his cervical spine was the prevailing factor for the herniated cervical disc and need for surgery. Medical treatment was reasonable and necessary to relieve claimant from the cumulative injury over the years up to June 22, 2011, and the injury was the prevailing factor that necessitated the treatment.

Dr. Koprivica testified claimant was temporarily totally disabled from June 21, 2011, to December 15, 2011, because of his repetitive injuries. For cumulative injury up to June 22, 2011, Dr. Koprivica rated claimant as having a 15% permanent cervical impairment.

Dr. Koprivica testified he reviewed medical bills and corresponding medical records for the treatment of claimant's neck and opined the charges were reasonable and necessary and claimant's injuries were the prevailing factor for those billings.[13]

For claimant's March 5, 2012, work injury, Dr. Koprivica diagnosed a C5-6 disc herniation for which he underwent a discectomy and fusion surgery and the injury was the prevailing factor. Dr. Koprivica rated claimant separately for the March 5, 2012 work accident at 25% whole person impairment.

Dr. Koprivica noted claimant did not function well after returning to work for respondent. The doctor's reports dated April 13 and August 30, 2013 attribute claimant's need for cervical spine restrictions to both injury dates.[14] For claimant's March 5, 2012 injury, Dr. Koprivica gave permanent restrictions to avoid repetitive overhead reaching or lifting; avoid sustained activities above shoulder girdle level; avoid repetitive motions of the head and neck; and avoid whole body vibration or jarring activities. Dr. Koprivica testified claimant's maximum lifting should be 45 pounds. He further testified his restrictions are prophylactic to prevent further injury and not an indication of claimant's physical capabilities.

Dr. Koprivica testified claimant will need lifelong treatment based on the March 5, 2012 injury, including non-operative chronic pain management, monitoring, possible injection therapies, medications, specialty care and possibly additional surgery for either myelopathy or new nerve root compression.

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[13] Dr. Pratt testified Dr. O'Boynick's bills were reasonable for cervical fusion surgery with before and after care.

[14] Koprivica Depo., Cl. Ex. 2 at 27, Cl. Ex. 5 at 2.

Dr. Koprivica reviewed vocational expert Mike Dreiling's report of August 13, 2013, listing 16 job tasks for claimant.[15] Dr. Koprivica testified claimant, due to his work injuries, could not perform 12 tasks for a 75% task loss. However, he also testified claimant's injury of March 5, 2012, would result in the same task loss by itself.[16] Dr. Koprivica characterized claimant's job at Zurich as a sedentary position that was not physically demanding. The doctor testified claimant's job requirements at Zurich were consistent with his restrictions and was appropriate employment. Dr. Koprivica did not think sitting down would place any particular stress on claimant's cervical spine.

Terrance Pratt, M.D., a court-appointed neutral physician, evaluated claimant on October 29, 2013. Claimant's chief complaint was cervical discomfort. Dr. Pratt noted in his report that claimant had no known symptomatic impairment prior to June 22, 2011 and he had no records showing prior neck treatment. Dr. Pratt reviewed medical records and took a history from claimant. Claimant told Dr. Pratt he had a slow onset of symptoms over a weekend of repetitive activities working with truck frames as a technician. Claimant did not recall a specific event, but reported lifting 75-85 pounds and frequently bending. Dr. Pratt could not recall claimant telling him that he did automotive work at home.

Claimant told Dr. Pratt the onset of his symptoms related to vocational activities continuing through June 2011 and his repetitive activities as a technician resulted in a slow onset of symptoms and something happened over the weekend to the point they were relevant to mention. Claimant told Dr. Pratt he felt his symptoms were related to working with truck frames. Claimant did not recall a specific incident, but his work required him to lift heavy weights and frequently bend.

Dr. Pratt testified claimant's work at home over the weekend prior to June 22, 2011, was a significant factor with respect to symptom onset, but claimant's work performed with respondent – 40 hours per week for at least eight years – would be more significant than the work at home and was the prevailing factor for his cervical spine injury. Dr. Pratt testified it is not uncommon with repetitive injury for a triggering event to happen with symptoms becoming unbearable several days later.

Drs. Pratt and Koprivica agreed, when considering Dr. Tenny's records, that there was a temporal relationship between claimant awakening on a Monday morning with pain in his neck and something he did over the prior weekend.

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[15] Mr. Dreiling stated claimant's job at Zurich was "a more sedentary claims adjusting position, which is a much better job for him . . . ." Cont. of R.H. Trans., Ex. 4 at 3.

[16] Koprivica Depo. at 48-49.

Dr. Pratt did not provide any rating for preexisting impairment and his report stated claimant had no known prior symptomatic impairment before June 22, 2011. However, Dr. Pratt testified he saw preexisting degenerative changes in claimant's cervical spine that would be rateable based on radiological reports, including his July 14, 2011 MRI and there "was potential for aggravation of the underlying degenerative changes with his activities."[17]

Dr. Pratt testified claimant had a 15% permanent partial disability due to his injuries through June 2011. Dr. Pratt's diagnosis for the injuries through June 2011 was cervicothoracic syndrome with C6-7 fusion. Dr. Pratt testified claimant's work activities with respondent through June 2011 were the most significant factor and the prevailing factor in his diagnosis, need for treatment and impairment rating.

Dr. Pratt's diagnosis for claimant's March 5, 2012 injury was C5-6 cervicothroacic herniation status post-fusion for which claimant had a 10% whole person permanent impairment. Dr. Pratt testified claimant's permanent restrictions are to avoid awkward positions of the cervical region and avoid forceful activities involving torquing as a result of his March 5, 2012, work injury. The doctor opined the prevailing factor for the diagnosis, restrictions and impairment is claimant's March 5, 2012 injury.

Dr. Pratt was not asked by the judge to provide restrictions for the first injury, but testified he likely would have limited claimant between light and medium physical demands after the first injury. Dr. Pratt testified claimant's permanent restrictions based on *both* injuries are 25 pounds maximum lifting, 50 pounds maximum push-pull, avoid cervical region awkward positions, and avoid forceful activities involving torquing. Dr. Pratt agreed claimant could perform light and sedentary work. He further testified:

> Q. And why would you impose lifting restrictions for the - - when the June, 2011, condition is included?
>
> A. You have a two-level fusion, and I would recommend limitations in lifting and pushing-pulling to prevent aggravation or additional injuries.[18]

Dr. Pratt testified claimant cannot perform 9 of 16 tasks when considering restrictions for both injuries. For only the second injury, Dr. Pratt testified claimant was able to perform all 16 tasks.

Dr. Pratt testified claimant will more probably require future medical treatment for his injuries. He will require monitoring for medications and laboratory studies. Depending on later symptoms and findings, claimant may require other treatments.

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[17] Pratt Depo. at 13.

[18] *Id.* at 44-45.

Claimant testified sitting while working for Zurich compressed his spine and intensified his headaches and he occasionally missed work due to his neck. He testified he could no longer perform sedentary work at Zurich because of his pain. Claimant was technically still on the payroll with Zurich, but was on short-term disability with his job about to end. The last day he actually worked at Zurich was June 6, 2014. Claimant testified he had not subsequently worked because of his neck pain, other than making repairs for friends and family eight to ten hours a week. He no longer works at home for the used car lot. Claimant denied any accidents or injuries to his neck while working at home.

Currently, claimant's symptoms include chronic daily headaches. Claimant testified he always has a headache unless he ices his neck. Claimant has severe neck pain and numbness and tingling every day from his neck into his right hand. Claimant testified he takes hydrocodone once or twice per day for his neck pain, prescribed by Dr. Crane. Dr. Lair prescribed claimant Cymbalta for nerve pain. Claimant also takes Advil once per day.

Claimant testified he lost his ability to lift and range of motion because of his neck surgeries. Claimant testified his symptoms, inability to lift and range of motion deficits preclude his return to his full duties for respondent or Zurich.

Mr. Dreiling's report indicated claimant earned about $22 per hour at Zurich and his realistic earning capacity was $885 per week. The $885 figure did not include the value of employer-provided fringe benefits, but Mr. Dreiling noted claimant's fringe benefits at Zurich were comparable to what he received from respondent. Similarly, claimant testified his fringe benefit package at Zurich was pretty similar to what respondent provided.

Pay records from Zurich show claimant was paid at varying hourly rates and earned some overtime pay. While at Zurich, excluding fringe benefits, he earned an average of $977.23 per week between February 18, 2013 and December 31, 2013, and an average of $1,057.30 per week between January 1, 2014 and June 15, 2014. The 2014 taxed earnings include a payment for the pay period of March 28, 2014 through March 28, 2014 (a single day) for $1,997.55 for something called "STIP Award Amount."[19]

Zurich contributed $750 to a health savings account for claimant in 2013 and $1,000 to such account in 2014. Claimant testified Zurich contributed 6% of his salary to a 401(k) plan. Zurich contributed $2,655.52 to something termed "Savings Company Matc"[20] in 2013 and $1,384.27 in 2014. Claimant testified this was probably his 401(k). Such figures represent 6% of claimant's respective earnings for both years, but excludes a contribution for the one day payment of $1,997.55 on March 28, 2014.

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[19] Cont. of R.H. Trans., Ex. 1 at 11.

[20] This is not a typographical error.

Claimant also testified Zurich contributed toward a pension, but there is no evidence regarding what the employer contribution may have been. Claimant also testified his monthly contribution toward Zurich's employer-provided insurance plan was $150 per month and Zurich likely contributed $310 per month. Claimant testified he could not provide such figures with certainty, but they represented his best guess.

At the regular hearing, the judge noted the first claim involved a whole body functional impairment and the second case involved a whole body injury and work disability. Claimant agreed the first case involved a functional impairment claim only.[21]

For Docket No. 1,064,108, while noting claimant's repetitive and heavy job duties and an alleged injury by repetitive trauma, the judge concluded claimant failed to prove a compensable accident, apparently because claimant did not produce symptoms of an injury at the time of an accidental injury and his symptoms did not occur in a single work shift. All other issues were ruled moot.

For Docket No. 1,064,109, the judge found claimant had a preexisting 15% functional impairment and a 14.5% work disability using a 29% wage loss based on Mr. Dreiling's opinion claimant could earn $885 per week when not including post-injury fringe benefits[22] and a 0% task loss based on Dr. Pratt's opinion. The judge also awarded claimant future medical treatment.

PRINCIPLES OF LAW

K.S.A. 2011 Supp. 44-501b(b) states an employer is liable to pay compensation to an employee incurring personal injury by accident or repetitive trauma arising out of and in the course of employment. According to K.S.A. 2011 Supp. 44-501b(c), the burden of proof shall be on the claimant to establish his or her right to an award of compensation and the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508 states in part:

> (d) "Accident" means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.

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[21] Cont. of R.H. Trans. at 3-4.

[22] Such finding necessarily required the judge to find claimant's average weekly wage at respondent was $1,250. The parties stipulated to an average weekly wage of $1,375.75 when including fringe benefits.

(e) "Repetitive trauma" refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury. "Repetitive trauma" shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.

In the case of injury by repetitive trauma, the date of injury shall be the earliest of:

(1) The date the employee, while employed for the employer against whom benefits are sought, is taken off work by a physician due to the diagnosed repetitive trauma;

(2) the date the employee, while employed for the employer against whom benefits are sought, is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;

(3) the date the employee, while employed for the employer against whom benefits are sought, is advised by a physician that the condition is work-related; or

(4) the last day worked, if the employee no longer works for the employer against whom benefits are sought.

In no case shall the date of accident be later than the last date worked.

(f)(1) “Personal injury” and “injury” mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.

(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.

(A) An injury by repetitive trauma shall be deemed to arise out of employment only if:

(i) The employment exposed the worker to an increased risk or hazard which the worker would not have been exposed in normal non-employment life;

(ii) the increased risk or hazard to which the employment exposed the worker is the prevailing factor in causing the repetitive trauma; and

(iii) the repetitive trauma is the prevailing factor in causing both the medical condition and resulting disability or impairment.

. . .

(3) (A) The words "arising out of and in the course of employment" as used in the workers compensation act shall not be construed to include:

(i) Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;

(ii) accident or injury which arose out of a neutral risk with no particular employment or personal character;

(iii) accident or injury which arose out of a risk personal to the worker; or

(iv) accident or injury which arose either directly or indirectly from idiopathic causes.

. . .

(g) "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor" in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

(h) "Burden of proof" means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act.

K.S.A. 2011 Supp. 44-510c states in part:

(2) (A) Temporary total disability exists when the employee, on account of the injury, has been rendered completely and temporarily incapable of engaging in any type of substantial and gainful employment.

. . .

(4) An employee shall not be entitled to receive temporary total disability benefits for those weeks during which the employee is also receiving unemployment benefits.

(c) When any permanent total disability or temporary total disability is followed by partial disability, compensation shall be paid as provided in K.S.A. 44-510d and 44-510e, and amendments thereto.

K.S.A. 2011 Supp. 44-510e states, in part:

(a)(2)(A) Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d, and amendments thereto.

. . .

(B) The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

(C) An employee may be eligible to receive permanent partial general disability compensation in excess of the percentage of functional impairment ("work disability") if:

(i) The percentage of functional impairment determined to be caused solely by the injury exceeds 7½% to the body as a whole or the overall functional impairment is equal to or exceeds 10% to the body as a whole in cases where there is preexisting functional impairment; and

(ii) the employee sustained a post-injury wage loss, as defined in subsection (a)(2)(E) of K.S.A. 44-510e, and amendments thereto, of at least 10% which is directly attributable to the work injury and not to other causes or factors.

In such cases, the extent of work disability is determined by averaging together the percentage of post-injury task loss demonstrated by the employee to be caused by the injury and the percentage of post-injury wage loss demonstrated by the employee to be caused by the injury.

(D) "Task loss" shall mean the percentage to which the employee, in the opinion of a licensed physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the five-year period preceding the injury. The permanent restrictions imposed by a licensed physician as a result of the work injury shall be used to determine those work tasks which the employee has lost the ability to perform. If the employee has preexisting permanent restrictions, any work tasks which the employee would have been deemed to have lost the ability to perform, had a task loss analysis been completed prior to the injury at issue, shall be excluded for the purposes of calculating the task loss which is directly attributable to the current injury.

(E) "Wage loss" shall mean the difference between the average weekly wage the employee was earning at the time of the injury and the average weekly wage the employee is capable of earning after the injury. The capability of a worker

to earn post-injury wages shall be established based upon a consideration of all factors, including, but not limited to, the injured worker's age, physical capabilities, education and training, prior experience, and availability of jobs in the open labor market. The administrative law judge shall impute an appropriate post-injury average weekly wage based on such factors. Where the employee is engaged in post-injury employment for wages, there shall be a rebuttable presumption that the average weekly wage an injured worker is actually earning constitutes the post-injury average weekly wage that the employee is capable of earning. The presumption may be overcome by competent evidence.

(i) To establish post-injury wage loss, the employee must have the legal capacity to enter into a valid contract of employment. Wage loss caused by voluntary resignation or termination for cause shall in no way be construed to be caused by the injury.

(ii) The actual or projected weekly value of any employer-paid fringe benefits are to be included as part of the worker's post-injury average weekly wage and shall be added to the wage imputed by the administrative law judge pursuant to K.S.A. 44-510e(a)(2)(E), and amendments thereto.

(iii) The injured worker's refusal of accommodated employment within the worker's medical restrictions as established by the authorized treating physician and at a wage equal to 90% or more of the pre-injury average weekly wage shall result in a rebuttable presumption of no wage loss.

. . .

(3) When an injured worker is eligible to receive an award of work disability, compensation is limited to the value of the work disability as calculated above. In no case shall functional impairment and work disability be awarded together.

K.S.A. 2011 Supp. 44-510h states, in part:

(a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment . . . as may be reasonably necessary to cure and relieve the employee from the effects of the injury.

(b) (1) If the director finds, upon application of an injured employee, that the services of the health care provider furnished as provided in subsection (a) . . . are not satisfactory, the director may authorize the appointment of some other health care provider. In any such case, the employer shall submit the names of two health care providers . . . . The injured employee may select one from the list who shall be the authorized treating health care provider. If the injured employee is unable to obtain satisfactory services from any of the health care providers submitted by the employer under this paragraph, either party or both parties may request the director to select a treating health care provider.

(2) Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such health care provider up to a total amount of $500. . . .

(e) It is presumed that the employer's obligation to provide the services of a health care provider . . . shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

K.S.A. 2011 Supp. 44-510j(h) states, in part:

If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director.

K.S.A. 2011 Supp. 44-520 states:

(a)(1) Proceedings for compensation under the workers compensation act shall not be maintainable unless notice of injury by accident or repetitive trauma is given to the employer by the earliest of the following dates:

(A) 30 calendar days from the date of accident or the date of injury by repetitive trauma;

. . .

Notice may be given orally or in writing.

. . .

(4) The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(b) The notice required by subsection (a) shall be waived if the employee proves that (1) The employer or the employer's duly authorized agent had actual knowledge of the injury . . . .

Board review of an order is de novo on the record.[23] A de novo hearing is a decision of the matter anew, giving no deference to findings and conclusions previously made by the judge.[24] The Board, on de novo review, makes its own factual findings.[25]

The determination of the existence, extent and duration of the injured worker's incapacity is left to the trier of fact.[26] The trier of fact decides which testimony is more accurate and/or credible and may adjust the medical testimony with the testimony of claimant and any other testimony relevant to the issue of disability. The trier of fact must decide the nature and extent of injury and is not bound by the medical evidence.[27]

ANALYSIS

DOCKET NO. 1,064,108

1. Claimant proved a compensable injury by repetitive trauma.

Claimant proved injury by repetitive trauma. Page eight of the judge's Award states Dr. Pratt was unable to identify an occupational endeavor that caused claimant's repetitive injuries. However, the Award states two pages later that Drs. Koprivica and Pratt indicated claimant's full-time and repetitive work was the prevailing factor in causing his injury, medical condition, impairment and disability. The Board finds the prevailing factor was claimant's heavy and repetitive work. "Uncontradicted evidence which is not improbable or unreasonable cannot be disregarded unless shown to be untrustworthy, and is ordinarily regarded as conclusive."[28] There was no contrary prevailing factor opinion. Contrary to the appealed ruling, the law for an injury by accident does not apply when analyzing what is a compensable injury by repetitive trauma.

Respondent alleges claimant was injured at home over the weekend prior to June 22, 2011. While claimant performed some mechanic work that weekend, there is no preponderance of evidence that he was injured in performing such work. Additionally, no physician identified claimant's work at home as the culprit which caused his injury.

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[23] See *Helms v. Pendergast*, 21 Kan. App. 2d 303, 899 P.2d 501 (1995).

[24] See *In re Tax Appeal of Colorado Interstate Gas Co.*, 270 Kan. 303, 14 P.3d 1099 (2000).

[25] See *Berberich v. U.S.D. 609 S.E. Ks. Reg'l Educ. Ctr.*, No. 97,463, 2007 WL 3341766 (Kansas Court of Appeals unpublished opinion filed Nov. 9, 2007).

[26] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 522 P.2d 395 (1974).

[27] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991), *superseded on other grounds by statute.*

[28] *Anderson v. Kinsley Sand & Gravel, Inc.*, 221 Kan. 191, Syl. ¶ 2, 558 P.2d 146 (1976).

Claimant's work exposed him to a risk or hazard he was not exposed to in his non-employment life. He worked with heavier weights at respondent's business and worked 40-60 hours per week, instead of working with lighter weights for fewer hours at home. Claimant also generally limited his work at home to 60-90 minutes at a time. Claimant's side work at home is not the equivalent of his work for respondent. Additionally, while respondent asserts claimant had an aggravation of a preexisting cervical condition, there is no proof claimant "solely" had an aggravation of a preexisting condition, as is statutorily required to defeat compensability under K.S.A. 2011 Supp. 44-508(f)(2).

2. Did respondent receive proper notice of his injury by repetitive trauma?

Claimant testified – in lukewarm fashion – that on June 22, 2011, he told his service manager his neck was injured due to his work for respondent. Claimant could not identify a specific injurious event, such as an accident. Claimant completed an accident report and his testimony that he prepared an incident or accident report is sufficient; he need not produce a copy of the report as well. Respondent sent him to an occupational medicine clinic, where he was told his injury was not compensable. This visit, while occurring on June 30, 2011, was paid by respondent under workers compensation insurance.

Claimant provided notice that he was injured at work. If claimant was injured apart from work, it makes little sense for respondent to have him complete an accident report and send him to, and pay for, an evaluation at a workers compensation clinic. It makes less sense for an occupational medicine doctor to tell claimant his condition was not work related, absent claimant, respondent or both questioning an industrial cause. Also, claimant's service manager did not refute claimant's testimony.

3. Claimant sustained a 15% whole person impairment as a result of his injury by repetitive trauma through June 22, 2011.

Both Drs. Koprivica and Pratt came to this conclusion, which the Board adopts. Based on the stipulation claimant's first accident concerned functional impairment only, claimant's injury by repetitive trauma cannot result in him being awarded work disability benefits in Docket No. 1,064,108.

4. Claimant is entitled to TTD from June 22 through December 15, 2011.

Only Dr. Koprivica testified regarding claimant's entitlement to TTD benefits. He opined claimant was temporarily and totally disabled for the time frame listed above.[29] Such opinion is not controverted and is adopted by the Board.

[29] Technically, Dr. Koprivica used a June 21, 2011 starting date, but we have adjusted his testimony to conform with the record.

Respondent argues claimant was paid for three weeks of vacation and also received short-term and long-term disability benefits, such that he was already compensated for his time off work. K.S.A. 2011 Supp. 44-510c prohibits an award of TTD while a claimant receives unemployment benefits, but has no similar restriction for paid time off, vacation pay or short/long-term disability benefits. Respondent did not argue claimant is estopped from receiving TTD after receiving short-term or long-term disability benefits. Reimbursement for any such payments is not within the Board's jurisdiction and would appear to be a contractual issue outside the Kansas Workers Compensation Act.

5. Claimant is awarded future medical treatment and unauthorized medical treatment, but respondent is not responsible to pay for claimant's unauthorized medical treatment in excess of the $500.

The Board adopts the opinion of Drs. Koprivica and Pratt that claimant will need future medical treatment. Claimant is entitled to up to $500 for unauthorized medical.

Apart from noting his bills in Claimant Ex. 3 at the continuation of the regular hearing were for reasonable and necessary treatment, and in appropriate amounts, claimant does not set forth an argument as to why respondent is responsible for paying such bills. For instance, there is no argument respondent knew claimant had a compensable work injury and refused or neglected to provide medical treatment, such that claimant could obtain treatment on his own at respondent's expense.[30] Respondent provided an evaluation at Corporate Care on June 30, 2011. The examining doctor told claimant his injury was not work related. It would be a stretch of the law to say respondent would need to ignore the company doctor's opinion and provide treatment for what the doctor termed non-compensable, lest it run the risk of having to pay for claimant's self-directed treatment. Claimant opted to proceed under his health insurance in lieu of contesting the denial of compensability by way of a preliminary hearing.

Also, most of the medical expenses for which claimant seeks payment were incurred after Dr. Bailey released him after the second injury. Respondent did not refuse or neglect to provide medical treatment. Dr. Bailey exhausted many options and even ordered tests that likely would not benefit claimant. If claimant wanted respondent to pay for his treatment after Dr. Bailey released him, he could have obtained a competing medical opinion and proceeded to a preliminary hearing. Instead, he simply incurred unauthorized medical expenses and billed his health insurance. Respondent is not responsible for claimant's unauthorized treatment, his out-of-pocket expenses, prescription reimbursement or medical mileage in either docketed case.

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[30] See *Saylor v. Westar Energy, Inc.*, 292 Kan. 610, 623, 256 P.3d 828, 837 (2011); K.S.A. 2011 Supp. 44-510j(h).

DOCKET NO. 1,064,109

1. Claimant has a 16.7% whole body functional impairment and his current work disability is 33.5%.

Physicians gave impairment ratings for claimant's March 5, 2012 injury by accident of 10%, 15% and 25%. The average rating is 16.7%, which the Board adopts. Calculating a work disability award hinges on wage loss and task loss, which we address separately.

A. Due to his March 5, 2012 injury by accident, claimant has varying wage loss percentages in excess of 10% while working at Zurich through June 15, 2014. He had six pay periods in which he did not have at least 10% wage loss required for a work disability award, so he is awarded functional impairment for those periods. Claimant has an 11% wage loss starting June 16, 2014.

Determining wage loss requires computation of claimant's average weekly wage (AWW) and his post-injury wage earning capability.[31] While the judge noted on page three of his Award that the parties stipulated claimant's AWW for respondent was $1,375.75 after fringe benefits were discontinued, he did not use such figure in his calculations.

For an employee earning post-injury wages, there is a rebuttable presumption the actual wages represent the wage the employee is capable of earning. As mandated by K.S.A. 2011 Supp. 44-510e(a)(2)(E)(ii), post-injury wage earning capability must include the actual or projected weekly value of employer-paid fringe benefits.

Drs. Koprivica and Pratt noted claimant could perform sedentary work. Dr. Koprivica indicated claimant's work at Zurich was appropriate and within his restrictions. Even though claimant is currently not working full-time, he hesitatingly concedes in his brief that he is able to earn $880 per week. Mr. Dreiling indicated claimant's realistic earning capacity was $885 per week, but such figure did not include the value of employer-provided fringe benefits and was not based on Zurich's records.

The Board disagrees with the judge's calculations regarding claimant's AWW and his post-injury wage earning capacity. The judge calculated claimant's wage loss based on his capability to earn $885 per week, but such figure did not include the value of fringe benefits. Based on "wage loss math," the judge had to have used $1,250 as claimant's AWW, a figure also listed in Mr. Dreiling's report as being claimant's AWW for respondent. The $1,250 figure in Mr. Dreiling's report is inaccurate.

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[31] Calculating claimant's AWW for respondent and his post-injury wage earning capacity were not listed as issues for review by the parties, but claimant's eligibility for a work disability cannot be addressed absent such determinations.

Additionally, there is a statutory presumption that when a worker is working, his or her actual post-injury wages represent his or her earning capability. In this case, not including fringe benefits, claimant earned an average of $977.23 per week between February 18, 2013 and December 31, 2013, and an average of $1,057.30 per week between January 1, 2014 and June 15, 2014. Mr. Dreiling's $885 figure is substantially less than these figures and less accurate than claimant's actual earnings.

Claimant's weekly fringe benefits at Zurich were $146.54 in 2013 and $171.91 in 2014 based on dividing respondent's $750 health savings account payment and its $2,655.52 IRA contributions by 45.29 weeks in 2013 and dividing respondent's $1,000 health savings account payment and its $1,384.27 IRA contributions by 23.71 weeks in 2014. For health, dental and vision insurance, the Board accepts claimant's testimony that respondent's contribution was $310 per month, which is $71.35 per week.

Claimant's actual post-injury earnings and fringe benefits represent his post-injury earning capability while he was working. His post-injury wage loss is detailed in the last two pages of this Order. Because he had less than a 10% wage loss in six of his pay periods, he is not entitled to work disability benefits during such time frames, but he gets permanent partial disability benefits based on his functional impairment during such weeks.

Respondent argues claimant voluntarily resigned and is thus not eligible for an award of work disability benefits based on K.S.A. 44-510e(a)(2)(E)(i), which states wage loss due to voluntary resignation cannot be construed as being caused by the injury. Respondent asserts claimant's resignation was voluntary because he quit his job for respondent when he had no physical restrictions and failed to ask for job modifications that may have allowed him to remain employed. The Board disagrees for these reasons:

- While there is no requirement that he ask for job modification, claimant testified he discussed alternative job positions with respondent. Claimant testified he resigned because he could not physically perform the work for respondent.

- The Board does not find claimant's lack of restrictions following a two-level fusion to be realistic. While Dr. Pratt's testimony is inconsistent, he noted lifting, pushing and pulling restrictions are appropriate following a two-level surgical fusion. Of three testifying physicians, only Dr. Bailey opined claimant required no restrictions.

- Given claimant's testimony that his pain compelled him to resign from respondent, we have difficultly characterizing his separation of employment as "voluntary." Claimant also left his heavy and repetitive work for respondent to accept an easier and more appropriate position with Zurich.

The Board finds claimant's current earning capability results in an 11% wage loss based on a $1,229.21 post-injury wage, which is what claimant averaged in 2014 when he worked for Zurich, including post-injury fringe benefits. Based on medical evidence, claimant retained the ability to perform such work.

B. Claimant sustained a 56% task loss due to his March 5, 2012 injury by accident.

Task loss is a more difficult question because the medical evidence is conflicting. As noted above, the Board finds restrictions are appropriate after a two-level fusion.

Dr. Koprivica's reports dated April 13 and August 30, 2013 attribute claimant's need for restrictions as due to *both* his June 22, 2011 and March 5, 2012 injury dates, but he testified claimant's March 5, 2012 injury resulted in the same restrictions and a 75% task loss. Dr. Koprivica is somewhat at odds with himself by saying in two reports claimant needs restrictions because of both injuries, but testifying claimant would have the same task loss when only considering the second injury. As a result, while we have considered Dr. Koprivica's testimony, we discount his task loss opinion.

Dr. Pratt testified he likely would have limited claimant to between light and medium physical demands after the first injury, but he was not asked to do so. Dr. Pratt testified claimant has permanent restrictions of avoiding awkward positions of the cervical region and forceful activities involving torquing as a result of his March 5, 2012, work injury. Dr. Pratt indicated both of claimant's injuries would result in claimant needing to restrict his maximum lift to 25 pounds, his maximum push-pull of 50 pounds, avoid awkward positions of the neck and avoid forceful activities involving torquing. When considering both injuries, Dr. Pratt testified he would preclude claimant from performing nine tasks. For only the second injury, Dr. Pratt testified claimant would be able to perform all 16 tasks, such that claimant had no task loss.

Dr. Pratt indicated lifting, pushing and pulling restrictions would have been appropriate following claimant's first injury and fusion. It makes little sense for claimant to need such restrictions after a single-level fusion, but not a two-level fusion. Indeed, Dr. Pratt's testimony highlights this inconsistency: he testified limitations in lifting, pushing and pulling are recommended following a two-level fusion. If the two-level fusion causes the need for lifting/pushing/pulling restrictions, such need is tied to the second accident.

We are not analyzing claimant's task loss as being due to the combined effects of both injuries. The Board concludes claimant's need for lifting, pushing and pulling restrictions are as appropriate following a one-level fusion as a two-level fusion. Further, while we do not fully embrace or understand the inconsistencies in Dr. Pratt's testimony, *Tovar* says we can adjust medical testimony to best assess a disability. We conclude Dr.

Pratt's opinion that claimant has a 56% task loss most accurately reflects his task loss following a two-level cervical fusion. We reject Dr. Pratt's opinion that claimant has no task loss due to the second accident. Claimant's task loss is due to the March 5, 2012 injury by accident.

Claimant's current 11% wage loss combined with his 56% task loss results in a 33.5% work disability.

The parties made no argument that claimant's repetitive injury through June 22, 2011, caused him restrictions which might diminish his task loss resulting from his March 5, 2012 accidental injury, as based on K.S.A. 2011 Supp. 44-510e(a)(2)(D). The Board is not supposed to unilaterally "[reach] out to grab" an issue "without a request . . . or notice to the parties."[32] The Board will not address an issue that was not raised. Similarly, the parties did not raise any arguments regarding whether respondent gets a credit for claimant's preexisting impairments, so we will not address that issue.

2. Claimant is entitled to future medical treatment. He also is entitled to unauthorized medical treatment, not to exceed $500.

The medical evidence establishes claimant will need future medical treatment. Claimant is also entitled to up to $500 for unauthorized medical. He is not entitled to reimbursement for unauthorized treatment, out-of-pocket expenses, prescription reimbursement or medical mileage in excess of $500, as explained on page 21.

CONCLUSIONS AND AWARD

WHEREFORE, having carefully reviewed the entire evidentiary file contained herein, the Board reverses the Award in Docket No. 1,064,108 and modifies the Award in Docket No. 1,064,109 as fully set forth herein.

In Docket No. 1,064,108, claimant is entitled to 25.29 weeks of temporary total disability compensation at the rate of $545 per week or $13,783.05 followed by 60.71 weeks of permanent partial disability compensation at the rate of $545 per week or $33,086.95 for a 15% whole body functional impairment, making a total award of $46,870.

As of October 16, 2015 there would be due and owing to the claimant 25.29 weeks of temporary total disability compensation at the rate of $545 per week in the sum of $13,783.05 plus 60.71 weeks of permanent partial disability compensation at the rate of $545 per week in the sum of $33,086.95 for a total due and owing of $46,870, which is ordered paid in one lump sum less amounts previously paid.

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[32] See *Goss v. Century Manufacturing, Inc.*, No. 108,367, 2013 WL 3867840 (unpublished Kansas Court of Appeals decision filed July 26, 2013).

In Docket No. 1,064,109, claimant is entitled to compensation based on the following periods of disability:

- for March 5, 2012 through July 25, 2012, or 20.43 weeks, permanent partial disability compensation at the rate of $555 per week or $11,338.65, for functional impairment.

- for July 26, 2012 through September 30, 2012, or 9.57 weeks, temporary total disability compensation at the rate of $555 per week or $5,311.35.

- for October 1, 2012 through February 28, 2013, or 21.57 weeks, permanent partial disability compensation at the rate of $555 per week or $11,971.35, for functional impairment.

- for March 1, 2013 through June 30, 2013, or 17.43 weeks, permanent partial disability compensation at the rate of $555 per week or $9,673.65, for work disability.

- for July 1, 2013 through July 15, 2013, or 2.14 weeks, permanent partial disability compensation at the rate of $555 per week or $1,187.70, for functional impairment.

- for July 16, 2013 through November 30, 2013, or 19.71 weeks, permanent partial disability compensation at the rate of $555 per week or $10,939.05, for work disability.

- for December 1, 2013 through December 15, 2013, or 2.14 weeks, permanent partial disability compensation at the rate of $555 per week or $1,187.70, for functional impairment.

- for December 16, 2013 through February 15, 2014, or 8.86 weeks, permanent partial disability compensation at the rate of $555 per week or $4,917.30, for work disability.

- for February 16, 2014 through March 31, 2014, or 6.29 weeks, permanent partial disability compensation at the rate of $555 per week or $3,490.95, for functional impairment; and

- for April 1, 2014 forward, or approximately 40.46 weeks, permanent partial disability compensation at the rate of $555 per week or $22,455.30, for work disability benefits.

These amounts make a total award, due and owing of $82,473, which is ordered paid in one lump sum less amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of October, 2015.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

DISSENT

K.S.A. 44-501(e) states:

(e) An award of compensation for permanent partial impairment, work disability, or permanent total disability shall be reduced by the amount of functional impairment determined to be preexisting. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

(1) Where workers compensation benefits have previously been awarded through settlement or judicial or administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be preexisting. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of preexisting functional impairment shall be established by competent evidence.

(2) In all cases, the applicable reduction shall be calculated as follows:

(A) If the preexisting impairment is the result of injury sustained while working for the employer against whom workers compensation benefits are currently being sought, any award of compensation shall be reduced by the current dollar value attributable under the workers compensation act to the percentage of functional impairment determined to be preexisting. The "current dollar value" shall be calculated by multiplying the percentage of preexisting impairment by the compensation rate in effect on the date of the accident or injury against which the reduction will be applied.

While the parties did not raise the issue of whether respondent gets a credit in the second claim for claimant's preexisting impairment from the first claim, the majority opinion does not apply the law as written. Respondent is entitled to a credit in Docket No. 1,064,109 for claimant's prior 15% impairment due to his injury by repetitive trauma through June 22, 2011. Calculating the credit is part and parcel of calculating claimant's award in the second case and fulfills the legislative mandate to do so.

_____
BOARD MEMBER

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Honorable Steven J. Howard, Administrative Law Judge

2013	Zurich wages	fringe benefits	total earnings	number of weeks	average weekly wage	wage loss %
02-18 to 02-28	$1,916.67	$230.07	$2,146.74	1.57	$1,367.35	0.01
03-01 to 03-15	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
03-16 to 03-31	$1,916.67	$335.58	$2,252.25	2.29	$983.52	29
04-01 to 04-15	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
04-16 to 04-30	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
05-01 to 05-15	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
05-16 to 05-31	$2,115.66	$335.58	$2,451.24	2.29	$1,070.41	22
06-01 to 06-15	$2,049.33	$313.60	$2,362.93	2.14	$1,104.17	20
06-16 to 06-30	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
07-01 to 07-15	$2,579.97	$313.60	$2,893.57	2.14	$1,352.14	0.02
07-16 to 07-31	$2,314.65	$335.58	$2,650.23	2.29	$1,157.31	16
08-01 to 08-15	$2,304.70	$313.60	$2,618.30	2.14	$1,223.51	11
08-16 to 08-31	$2,049.33	$335.58	$2,362.93	2.29	$1,031.85	25
09-01 to 09-15	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
09-16 to 09-30	$2,005.10	$313.60	$2,318.70	2.14	$1,083.51	21
10-01 to 10-15	$2,248.31	$313.60	$2,561.91	2.14	$1,197.15	13
10-16 to 10-31	$2,314.65	$335.58	$2,650.23	2.29	$1,157.31	16
11-01 to 11-15	$1,916.67	$313.60	$2,230.27	2.14	$1,042.18	24
11-16 to 11-30	$2,314.65	$313.60	$2,628.29	2.14	$1,228.15	11
12-01 to 12-15	$2,397.56	$313.60	$2,711.16	2.14	$1,266.90	8
12-16 to 12-31	$2,314.65	$335.58	$2,650.23	2.29	$1,157.31	16

2014	Zurich wages	fringe benefits	total earnings	number of weeks	average weekly wage	wage loss %
01-01 to 01-15	$2,122.98	$367.89	$2,490.87	2.14	$1,163.96	15
01-16 to 01-31	$2,115.66	$393.67	$2,509.33	2.29	$1,093.78	20
02-01 to 02-15	$1,916.67	$367.89	$2,284.56	2.14	$1,067.55	22
02-16 to 02-28	$2,115.66	$319.75	$2,435.41	1.86	$1,309.36	5
03-01 to 03-15	$2,314.65	$367.89	$2,682.54	2.14	$1,253.52	9
03-16 to 03-31	$2,115.66 + $1,997.55 on 3-28	$393.67	$4,506.88	2.29	$1,968.07	none
04-01 to 04-15	$2,016.78	$367.89	$2,384.67	2.14	$1,114.33	17
04-16 to 04-30	$1,953.08	$367.89	$2,320.97	2.14	$1,084.57	21
05-01 to 05-15	$2,155.85	$367.89	$2,523.74	2.14	$1,179.32	14
05-16 to 05-31	$2,155.85	$393.67	$2,549.52	2.29	$1,113.33	19
06-01 to 06-15	$2,088.26	$367.89	$2,456.15	2.14	$1,147.73	17